REVISION DATES: 10/15/2015 CORRECTION: FIELDS 71, 78, 79, 81
                       09/15/2015; 10/01/2014

Note: Effective October 1, 2014, AHCCCS determines Medicaid reimbursement for most acute care hospital inpatient services for the majority of Arizona hospitals, and out-of-state hospitals, using a Diagnosis Related Group (DRG) payment methodology.

Refer to FFS Chapter 11 Hospital Services Addendum APR-DRG for specific billing requirements of the DRG reimbursement methodology.

Introduction

The UB-04 claim form is used to bill for all hospital inpatient, outpatient, and emergency room services. Dialysis clinic, nursing home, free-standing birthing center, residential treatment center, and hospice services also are billed on the UB-04.

Revenue codes:
- are used to bill line-item services provided in a facility.
- must be valid for the service provided.
- must be valid for the bill type on the claim.

ICD diagnosis codes:

- are required. AHCCCS does not accept DSM-4 diagnosis codes, and behavioral health services billed with DSM-4 diagnosis codes will be denied.

- must be used to identify surgical procedures billed on the UB-04.

CPT/HCPCS codes and modifiers must be used to identify other services rendered.

NOTE: This chapter applies to *paper* UB-04 claims submitted to AHCCCS *for DRG-excluded facilities*. For information on HIPAA-compliant 837 transactions, please consult the appropriate Implementation Guide. Companion documents for 837 transactions are available on the AHCCCS web site at www.azahccs.gov The companion documents are intended to supplement, but not replace, the 837 Implementation Guides for the 837 transaction.

Refer to FFS Chapter 11 Hospital Services Addendum APR-DRG for facilities excluded from the APR-DRG reimbursement methodology.

Completing the UB-04 Claim Form

The following instructions explain how to complete the UB-04 claim form and whether a field is "Required," "If applicable," "Not required", or "Situational". These instructions are to be supplemented with the information and codes in the *Uniform Billing Manual for the UB-04.*

1.   Provider Data   **Required**
        Enter the name, address, and phone number of the provider rendering service.

1
Arizona Hospital **123 Main Street** **Scottsdale, AZ 85252**

2.   Billing Provider's Designated Pay-to Address   Required if applicable

        Report only when different from address reported in FL 1

3.a   Patient Control No.   Required if applicable
        This is a number that the facility assigns to uniquely identify a claim in the
        facility's records. AHCCCS will report this number in correspondence, including
        the Remittance Advice, to provide a cross-reference between the AHCCCS
        Claim Reference Number (CRN) and the facility's accounting or tracking
        system.

3.b   Medical/Health Record Number   Required if applicable

4.   **Bill Type**   **Required**
Facility type (1st digit), bill classification (2nd digit), and frequency (3rd digit).
See *UB-04 Manual* for codes.

2.	3a PATIENT CONTROL NO.	4. TYPE OF BILL
	3b MED REC #	111

5.   **Fed Tax No.**   **Required**
Enter the facility's federal tax identification number.

5. FED TAX NO.	6. STATEMENT COVERS PERIOD		7. COV D
	FROM	THROUGH	
86-1234567			

6.   **Statement Covers Period**   **Required**
Enter the beginning and ending dates of the billing period.

5. FED TAX NO.	6. STATEMENT COVERS PERIOD		7. COV D
	FROM	THROUGH	
	02/15/14	02/20/14	

Or

	02/15/2014	02/20/2014	

8.   Patient Name/Identifier   **Required**
Enter the recipient's last name, first name, and middle initial as they appear on
the AHCCCS ID card.

9.   Patient Address   **Required**

10.   Patient Birth Date   **Required**

11.   Patient Sex   **Required**

12.   Admission/Start of care date   **Required**

12 ADMISSION/START OF CARE	13 ADMISSION HOUR

13.   Admission hour   **Required if applicable**

14.   Priority (type) of Admission/Visit   **Required**
Required for all claims. Enter the code that best describes the recipient's status
for this billing period. See *UB-04 Manual* for codes.

15.   Point of Origin for Admission or Visit   **Required**

16.   Discharge Hour   **Required if applicable**
Enter the code which best indicates the recipient's time of discharge. Required for
inpatient claims when the recipient has been discharged. See *UB-04 Manual* for
code structure.

17.   Patient discharge status   **Required**
Required for all claims. Enter the code that best describes the recipient's status for
this billing period. See *UB-04 Manual* for codes.

18-28 Condition Codes   Required if applicable

Enter the appropriate condition codes that apply to this bill. See *UB-04 Manual* for codes.

In-state, non-IHS inpatient hospitals may request outlier consideration for a claim by entering "61" in any Condition Code field.

To bill for self-dialysis training, free-standing dialysis facilities approved to provide self-dialysis training must enter "73" in any Condition Code field and bill revenue code 841 (Continuous Ambulatory Peritoneal Dialysis, per day) or revenue code 851 (Continuous Cycling Peritoneal Dialysis, per day).

To bill for multiple distinct/independent outpatient visits on the same day facilities must enter "GO".

29.   Accident State   **Required if applicable**

31-34 Occurrence Codes and Dates   **Required if applicable**

35-36. Occurrence Span codes and dates   **Required if applicable**

38.   Responsible Party Name and Address   **Required if applicable**

39-41   Value Codes and Amounts   **Required if applicable**

42.   Revenue Code   **Required**

Enter the appropriate revenue code(s) that describe the service(s) provided. See *UB-04 Manual* for revenue codes and abbreviations. Revenue codes should be billed chronologically for accommodation days and in ascending order for non-accommodation revenue codes. Accommodation days should not be billed on outpatient bill types.

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES
1	132		
2	251		
3	258		
4			

43. **Revenue Code Description/NDC (effective 7/1/12)   Required/NDC if applicable**
Enter the description of the revenue code billed in Field 42. See *UB-04 Manual* for description of revenue codes.

*To report the NDC on the UB04 claim form, enter the following information into the Form Locator 43 (Revenue Code Description):

- The NDC Qualifier of N4 in the first 2 positions on the left side of the field.

- The NDC 11-digit numeric code, without hyphens.

- The NDC Unit of Measurement Qualifier*

- The NDC quantity, administered amount, with up to three decimal places (i.e. 1234.456). Any unused spaces are left blank.

The information in the Revenue Description field is 24 characters in length and is entered without delimiters, such as commas or hyphens.

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES	46. SERV. UNITS
1	0250	N400074115278 ML10	J1642	2.00
2				
3				

*Refer to the AHCCCS Pharmacy webpage for billing details at
http://www.azahcccs.gov/commercial/Downloads/PharmacyUpdates/NDCBillingRequirementsFAQs_Additional.pdf

44.   HCPCS/Rates   Required if applicable
Enter the inpatient (hospital or nursing facility) accommodation rate. Dialysis
facilities must enter the appropriate CPT/HCPCS code for lab, radiology, and
pharmacy revenue codes (See Chapter 15, Dialysis Services). Hospitals must
enter the appropriate CPT/HCPCS codes and modifiers when billing for
outpatient services (See Chapter 11, Hospital Services).

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES
1			1,088.00
2			85595
3			95900
4			

- Form Locator 44 (HCPCS/Rate/HIPPS code): Enter the corresponding HCPCS
  code associated with the NDC.

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES	46. SERV. UNITS
1	0250	N400074115278 ML10	J1642	2.00
2				
3				

45.   Service Date   Required
The dates indicated outpatient service was provided on a series bill. The date of
service should only be reported if the From and Through dates in Form Locator 6 are not
 each other on the form. Enter the date in MM/DD/YY or MM/DD/YYYY format.

46.   Service Units   **Required**

Number of units for ALL services must be indicated.

If accommodation days are billed, the number of units billed must be consistent with the patient status field (Field 17) and statement covers period (Field 6). If the recipient has been discharged, AHCCCS covers the admission date to, but not including, the discharge date. Accommodation days reported must reflect this. If the recipient expired or has not been discharged, AHCCCS covers the admission date through last date billed.

46. SERV. UNITS	47. TOTAL CHARGES	48. NON-COVERED CHARGES	49.
2.00			
3.00			
30.00			

- Form Locator 46 (Serv Units/HCPCS Units): Enter the number of HCPCS units administered.

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES	46. SERV. UNITS
1	0250	N400074115278 ML10	J1642	2.00
2				
3				

47.   Total Charges   **Required**

Total charges are obtained by multiplying the units of service by the unit charge for each service. Each line other than the sum of all charges may include charges up to $999,999.99. Total charges are represented by revenue code 001 and must be the last entry in Field 47. Total charges on one claim cannot exceed $999,999,999.99.

46. SERV. UNITS	47. TOTAL CHARGES		48. NON-COVERED CHARGES		49.
	2,176	00			
	104	26			
	529	92			

48.   Non-covered Charges   **Required if applicable**

Enter any charges that are not payable by AHCCCS. The last entry is total non-covered charges, represented by revenue code 001. Do not subtract this amount from total charges.

50.
(A–C) Payer   **Required**

Enter the name and identification number, if available, of each payer who may have full or partial responsibility for the charges incurred by the recipient and from which the provider might expect some reimbursement. If there are payers other than AHCCCS, AHCCCS should be the last entry. If there are no payers other than AHCCCS, AHCCCS will be the only entry.

	50. PAYER	51. PROVIDER NO.	52. REL INFO		53. ASG BEN
A	AHCCCS				
B					
C					

51.
(A–C) Healthplan Identification No.   **Required**

Enter the facility's ID number as assigned by the payer(s) listed in Fields 50 A, B, and/or C. The facility's six-digit *AHCCCS service provider ID number* should be listed last. Behavioral health providers must not enter their BHS provider ID number.

	50. PAYER	51. PROVIDER NO.	52. REL INFO		53. ASG BEN
A		654321			
B					
C					

52.
(A–C) Release of Information   **Not required**

53.
(A–C) Assignment of Benefits   **Not required**

54.
(A–C) Prior Payments   **Required if applicable**
Enter the amount received from Medicare Part B (Inpatient Only) or any other
insurance or payer *other than AHCCCS*, including the patient, listed in Field 50. If
the recipient has other insurance but no payment was received, enter "Ø." The "
Ø " indicates that a reasonable attempt was made to determine available
coverage and obtain payment. Enter only actual payments received. Do not
enter any amounts expected from AHCCCS.

55.
(A–C) Amount due   **Not required**

56.   National Provider Identifier-Billing Provider   **Required**

57.   Other (Billing) Provider Identifier   **Required if applicable**

58.
(A–C) Insured's Name   **Not Required**
Enter the name of insured (AHCCCS recipient) covered by the payer(s) in Field
50.

	58. INSURED'S NAME	59. P.REL.	60. CERT. – SSN - HIC. - ID NO.
A	Holliday, John H.		
B			
C			

59.
(A–C) Patient's Relationship To Insured   **Not required**

60.A.   Patient ID Number   **Required**

Enter the recipient's AHCCCS ID number. If there are questions about eligibility or the AHCCCS ID number, contact the AHCCCS Verification Unit. (See Chapter 2, Recipient Eligibility and Enrollment). Behavioral health providers must be sure to enter the client's AHCCCS ID number, not the client's BHS number.

	58. INSURED'S NAME	59. P.REL.	60. CERT. –SSN - HIC. - ID NO.
A			A12345678
B			
C			

61.
(A–C) Group Name   **Not required**

Enter "FFS" for AHCCCS   AIHP and ESP recipients.

60. CERT. –SSN - HIC. - ID NO.	61. GROUP NAME	62. INSURANCE GROUP NO.
	FFS	

62.
(A–C) Insurance Group Number   **Not required**

63.(A–C) Treatment Authorization   **Not required**

        The AHCCCS claims system automatically searches for the appropriate
        authorization for services that require authorization. See Chapter 8,
        Authorizations, for information on prior authorization.

64.   **Document Control Number**   **Not required**

65.(A–C) Employer Name   **Not required**

66.   **Diagnosis and Procedure Code Qualifier**   **Required**

67.   **Principal Diagnosis Code**   **Required**

        Enter the **principal** *ICD diagnosis code.*
        Behavioral health providers must **not** use DSM-4 diagnosis codes.

66. PRIN. DIAG CODE	OTHER DIAG. CODES							
	68. CODE	69. CODE	70. CODE	71. CODE	72. CODE	73. CODE	74. CODE	75. CODE
585.0								

69.   **Admitting Diagnosis**   **Required**

        Required for inpatient bills. Enter the ICD diagnosis code that represents the
        significant reason for admission.

70.   **Patient's Reason for Visit**   **Not required**

71.   **PPS Code**   **Not required**

72   **E-Codes**   **Required if applicable**

        Enter trauma diagnosis code, if applicable.

74.   **Principal Procedure Code and Dates**   **Required if applicable**
Enter the principal ICD procedure code and the date the procedure was
performed during the inpatient stay or outpatient visit. Enter the date in
MM/DD/YY or MM/DD/YYYY format. If more than one procedure is performed,
the principal procedure should be the one that is related to the primary
diagnosis, performed for definitive treatment of that condition, and which
requires the highest skill level.

76.   **Attending Provider name and identifiers**   **Required if applicable**
NPI, ID

77.   **Operating Physician Name and Identifiers**   **Required if applicable**
NPI, ID

78.   **Referring Provider**   **Required if applicable**
NPI

79.   **Other Physician**   **Not required**

80.   **Remarks**   **Required if applicable**
Required on resubmissions, adjustments, and voids.

Enter the CRN of the claim that is being replaced by this resubmission,
adjustment, or void. For resubmissions of denied claims, write "Resubmission"
in this field.

81. a   **Other Procedure Codes**   **Required if applicable**
Enter taxonomy code

81. b-d **Other Procedure Codes**   **Not required**

Revision History

Date	Description of changes	Page(s)
10/15/2015	Field 43: added AHCCCS Pharmacy website address for NDC billing information Correction to fields: 60 - Required 71 – added 78, 79 split into 2 separate items 81 split into 2 separate items	7 13 14 15 15
09/15/2015	New format "ICD-9" replaced with "ICD"	All multiple
10/01/2014	APR-DRG effective	All